



APPLICATION FOR REGISTRATION AS A NON-RESIDENT PHARMACY IN THE STATE OF INDIANA

State Form 50248 (R / 7-02)

Approved by State Board of Accounts, 2002

FOR OFFICE USE ONLY

Application fee

Date fee paid

Receipt number

In accordance with IC 25-26-17, complete this form to register with the Indiana Board of Pharmacy as an out of state pharmacy. In addition, registration is contingent upon compliance with all requirements of IC 25-26-17 (*see attached copy*). **No application will be processed without the required fee.**

Verification of current unrestricted license or certificate of the pharmacy and all pharmacists listed is also required. Please forward the attached form to your state board of pharmacy for completion. No registration will be issued by the Indiana Board of Pharmacy until this form, the verification form, the fee, and the additional forms are received.

Mail this form, the requested information, and the fee to the Indiana Board of Pharmacy, 402 West Washington Street, Room 041, Indianapolis, IN 46204. If you need additional information or assistance, please contact the Indiana Board of Pharmacy.

Name of pharmacy

Address of pharmacy (number and street)

City

State

ZIP code

Name of pharmacist-in-charge

State

License number

Toll free telephone number, accessible from Indiana

Local telephone number, including area code

E-mail address

Web site address

Please attach a list of the names, titles, and cities of residence of all corporate officers and staff pharmacists, including the pharmacists' license numbers.

- The name, title, and city of residence of all corporate officers and pharmacists must be updated annually.
- The Indiana Board of Pharmacy must be notified of any changes of pharmacy location, corporate officer, or pharmacist in charge within thirty (30) days.

By signing below, I verify that the information on this application is true and accurate. I further verify that the pharmacy listed above has complied in the past and will comply in the future with all lawful requests for information from the regulatory agencies of all states in which it is licensed or registered, including Indiana. I further certify that the pharmacy listed above will maintain records of drugs dispensed to patients in Indiana, in a manner which makes these records readily retrievable and identifiable from other business records of the pharmacy. I also verify that I have received a copy of Indiana Code 25-26-17 and I have read it and I understand my responsibilities to the Indiana Board of Pharmacy.

Signature of applicant

Date signed (*month, day, year*)

Printed name of applicant

**INDIANA BOARD OF PHARMACY
NON-RESIDENT PHARMACY APPLICATION
QUESTIONS FOR PHARMACIST-IN-CHARGE**

State Form 50248 (R / 7-02)

Date (month, day, year)

Name of pharmacy			
Address of pharmacy (number and street)			
City		State	ZIP code
Toll free telephone number, accessible from Indiana		Local telephone number, including area code	
Name of pharmacist-in-charge		State	License number
List the approximate number of Indiana residents to be served:			
List the days of the week and hours that a pharmacist is available to speak to your Indiana patients about their medication:			
When a pharmacist is answering questions from Indiana patients on the toll-free telephone line, does the pharmacist have immediate access to the records and the drug profile of the patient they are speaking with? (If the answer is no, please explain.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
List the delivery services utilized to deliver medications to residents in Indiana and the percentage of time each service is utilized in Indiana:			
Delivery Service Utilized			Percentage of Time Utilized
Are there any special packaging or shipping procedures used to assure proper shipping conditions for the medications being shipped to Indiana residents? Please explain.			
When medications are delivered to Indiana residents, are there any special delivery policies in place? (Check those that apply.) <input type="checkbox"/> Medications must be signed for by _____ <input type="checkbox"/> Medications may be left with a non-adult person at the household. <input type="checkbox"/> Medications may be left at the house when no one is at home. <input type="checkbox"/> Medications do not have to be signed for. <input type="checkbox"/> Other, please explain your policy.			
The following item and documents must also accompany this application: <input type="checkbox"/> A sample label that will be used on the medication containers of Indiana residents. <input type="checkbox"/> A copy of the last Board inspection report by your home state board.			
I swear or affirm that the information provided on and with this application is accurate to the best of my knowledge.			
Signature of pharmacist-in-charge		Date signed (month, day, year)	
Printed name of pharmacist-in-charge			

NON-RESIDENT PHARMACY LICENSE VERIFICATION FOR REGISTRATION WITH THE INDIANA BOARD OF PHARMACY

State Form 50248 (R / 7-02)

This form must be completed by the applicant and the board of pharmacy of the state in which the applicant is located, and returned to the Indiana Board of Pharmacy before registration as a non-resident pharmacy will be issued.

Name of pharmacy			
Address of pharmacy (<i>number and street</i>)			
City		State	ZIP code
Name of pharmacist-in-charge		State	License number
Toll free telephone number, accessible from Indiana		Local telephone number, including area code	
List the names, license numbers, and cities of residence of all staff pharmacists: (<i>use a separate piece of paper if necessary</i>)			

The following section is to be completed by the Board of Pharmacy of the state in which the applicant is located:			
Is the pharmacy properly licensed or registered in your state?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the pharmacy currently in compliance with the laws of your state?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the pharmacy ever been non-compliant with the laws or rules of your state?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have any of the named pharmacists been disciplined in your state?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If the answer to either of the last two questions is "yes", please provide additional details pertaining to the offenses on a separate page, and / or copies of the pertinent legal documents.			
Printed name and title of State Official		State	
Signature of State Official		Date signed (<i>month, day, year</i>)	
<div style="text-align: center;">Please return this form to: Indiana Board of Pharmacy 402 West Washington Street, Room 041 Indianapolis, IN 46204 Telephone: (317) 234-2067</div> <div style="text-align: center; margin-top: 20px;">SEAL</div>			